EPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3)				

DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155254 05/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5430 WEST U.S. 40 SUGAR CREEK REHABILITATION CONVALESCENT CENTER GREENFIELD, IN46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0000 This plan of correction is to F0000 This visit was for the Recertification and serve as Sugar Creek State Licensure Survey. This visit **Rehabilitation Convalescent** included the Investigation of Complaint Center's credible allegation IN00090390. of compliance. We are in full compliance as of 05/27/2011 Complaint IN00090390 - Unsubstantiated and respectfully request paper review. due to lack of evidence. Submission of this plan of Survey dates: May 9, 10, 11, and 12, correction does not constitute 2011 an admission by Sugar Creek **Rehabilitation Convalescent** Center's or it's management Facility number: 000157 company that the allegations Provider number: 155254 contained in the survey report AIM number: 100274720 are a true and accurate portrayal of the provision of Survey Team: nursing care and other services in this facility. Nor Barbara Gray, RN TC does this submission Sharon Lasher, RN constitute an agreement or Angel Tomlinson, RN admission of the survey Karina Gates, Generalist Surveyor allegations. Leslie Parrett, RN (May 12, 2011) Census bed type: SNF/NF: 47 Total: 47 Census payor type: Medicare: 3 Medicaid: 39 Other: 5 47 Total:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

640911

Facility ID:

000157

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155254	B. WING		<del></del>	05/12/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			5430 W	'EST U.S. 40		
	CREEK REHABILITA	ATION CONVALESCENT CENTER	₹	GREEN	IFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	Sample: 13						
	Supplemental sample: 1						
	These deficiencie	es reflect state findings					
	cited in accordance with 410 IAC 16.2.						
	01000 111 000 01 0001						
	Ouality review co	ompleted on May 17,					
2011 by Bev Faulkner, RN							
F0282 SS=D	facility must be pro	ided or arranged by the byided by qualified persons					
	in accordance with plan of care.	n each resident's written					
		ation, interview and	F0	282	F282 483.20(k)(3)(ii) SERVICES		05/27/2011
		e facility failed to follow	10.	202	BY QUALIFIED PERSONS P		03/27/2011
	,	er for Med Pass for 1 of			CARE PLAN		
		ne sample of 13 reviewed			It is the manation of Common Case	اد	
		ysician orders. (Resident			It is the practice ofSugar Cre- Rehabilitation Convalescent	ек	
	# 35).	,			Center to provide services by	,	
					qualified persons in accordar		
	Findings include				with each resident's written p	lan	
	<i>G</i> 2				of care.		
	On 5/10/11 at 8:1	12 A.M., Resident #35			I. Resident #35 is receiving the		
		ceiving medications with			Med Pass nutritional supplen	nent	
		ounces of water from			as ordered. LPN #7 was re-educated during the survey		
		nt #35 was seated in the			regarding the importance of	у	
	dining room. Re	sident #35 was able to			providing supplements as or	dered	
					by the attending physician.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

640911

Facility ID:

000157

If continuation sheet

Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	LETED
		155254	B. WIN			05/12/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1	EST U.S. 40		
SUGAR	CREEK REHABILI	TATION CONVALESCENT CENT	ER	GREEN	IFIELD, IN46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	<b>†</b>	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	take the medicat				II. Desidente receiving physi	iolon	
	independently when handed to her. On				II. Residents receiving physicordered supplements have to the control of the c		
	5/10/11 at 9:20 A	A.M., Resident #35 was			reviewed to ensure that the	JCCII	
	observed receiving	ing eye drop medication			supplement is being offered	and	
	from LPN #7. F	Resident #35 tolerated the			documented in amount		
	administration v	vell. During both			consumed.		
		esident #35 responded to			III. Duning gungaya nayyadi		
	1	iately with clear speech.			III. During survey a new poli was formulated regarding	СУ	
		inverse with the species.			supplement administration a	ind	
	Resident #35's r	ecord was reviewed on			documentation. This was		
		P.M. Diagnoses included			provided to the surveyors.		
	1	<del>-</del>			Licensed nurses were educa		
	but were not limited to dementia,				on this new policy. Residen		
	weakness and ci	nronic renal insufficiency.			with physician orders for spe supplements will be provide		
					those supplements by the	u	
	1	uarterly Minimum Data			licensed nurse who will docu	ument	
	1	dated 3/11/11, indicated			administration and amount		
	the following: I	Resident #35 made herself			consumed on the resident's		
	understood and	had the ability to			medication administration re	ecord	
	understand other	rs. Resident #35 required			(MAR).		
	limited assistance	ce of 1 person for bed			IV. The DON or her designe	e is	
	mobility, transfe	er, to walk in her room,			conducting quality improven		
	and toileting. R	esident #35 required			audits to ensure that physici	an	
	"	setup help only for			ordered supplements are		
	eating.	Total merb emily res			provided as ordered. A rand sample of 5 residents are be		
	cuting.				reviewed weekly for 30 days	•	
	Reconciliation	of the medication pass was			monthly for 6 months. This		
		10/11 at 1:45 P.M.			includes a visual observation		
	_				see that the resident was		
	1 -	rs for Resident #35			administered the supplemen	nt and	
	1	lowing: 4/12/11 at no			that the supplement was documented accurately. Th	A	
	1 ^	Give 1 can of Nepro (or			interdisciplinary nutrition at r		
	1	iendly" supplement)			(NAR) committee will assist		
	,	a day) for weight loss.			monitoring during weekly NA	AR	
	4/15/11 at 3:00 l	P.M Give 90 milliliters			meetings. Results of all aud		
	(ml) of Med Pas	s (supplement) T I D (3			will be provided to the facility	y's	

000157

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 05/12/2011
	PROVIDER OR SUPPLIER	ATION CONVALESCENT CENTE	5430 W	ADDRESS, CITY, STATE, ZIP CODE /EST U.S. 40 NFIELD, IN46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DATE
	1:50 P.M., indicated her phy approximately 10 not be so close to indicated Reside of the Nepro. LI not offer Resider ordered Med Past didn't like the tast LPN #7 indicated supplement was because Residen "last month". LI #35 also received juice at breakfast	ordered by the physician t #35 had a weight loss PN #7 indicated Resident d supplement 206 orange t. LPN #7 indicated she if she could get the Med		Quality Assurance Commit monthly for additional recommendations if necess	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE				I	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155254	B. WIN			05/12/2	011
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
SUGAR (	CREEK REHABILIT	TATION CONVALESCENT CENTER	?	l	/EST U.S. 40 IFIELD, IN46140		
(X4) ID	SUMMARY S	RY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514 SS=D	each resident in a professional stand complete; accurat accessible; and sy	naintain clinical records on ecordance with accepted lards and practices that are ely documented; readily estematically organized.					
	The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.						
	Based on observation, interview and	F0	514	F514 483.75(I)(1) RES	0110	05/27/2011	
	record review, the facility failed to				RECORDS-COMPLETE/ACC ATE/ ACCESSIBLE	CUR	
	accurately docum	nent Med Pass for 1 of 13			ATE/ ACCESSIBLE		
	residents in the s	ample of 13 reviewed for			It is the practice of Sugar Cro	eek	
	accurate and con	nplete documentation.			Rehabilitation Convalescent		
	(Resident # 35).				Center to maintain each resi		
	Findings include	:			s clinical record in accordance with accepted professional standards and practices that are complete; accurately		
	On 5/10/11 at 8:1	12 A.M., Resident #35			documented; readily accessi		
	was observed rec	ceiving medications with			and systematically organized	J.	
		ounces of water from			I. Resident #35 is receiving t	he	
	LPN #7. Reside	nt #35 was seated in the			Med Pass nutritional suppler		
	dining room. Re	esident #35 was able to			as ordered. LPN #7 was		
	take the medicati	ions and water			re-educated during the surve regarding the importance of	<b>∋</b> y	
	independently w	hen handed to her.			providing supplements as or	dered	
					by the attending physician.		
	Resident #35's re	ecord was reviewed on					
	5/11/11 at 2:00 P	P.M. Diagnoses included			II. Residents receiving physic		
	but were not lim	ited to dementia,			ordered supplements have be reviewed to ensure that the	een	
	weakness and ch	ronic renal insufficiency.			supplement is being offered	and	
		-			documented in amount		
	Resident #35's qu	uarterly Minimum Data			consumed.		
	•	dated 3/11/11, indicated			III. During survey a new polic	СУ	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155254	B. WIN			05/12/2011
			B. ((1))		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	-			/EST U.S. 40	
SUGAR (	CREEK REHABILIT	ATION CONVALESCENT CENTER	₹	1	NFIELD, IN46140	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE
	the following: Resident #35 made herself				was formulated regarding	
	understood and h	and the ability to			supplement administration a	na
	understand other	S.			documentation. This was provided to the surveyors.	
					Licensed nurses were educa	uted
	Physician's order	rs for Resident #35 on			on this new policy. Resident	I
	-	.M., indicated the			with physician orders for spe	ecific
		90 milliliters (ml) of			supplements will be provided	t l
	Med Pass T.I.D.	* *			those supplements by the	
	IVICU FASS 1.1.D.	(3 tilles a day).			licensed nurse who will docu administration and amount	ment
	D '11' .'	0.1			consumed on the resident's	
		f the medication pass was			medication administration re	cord
	completed on 5/10/11 at 1:45 P.M. An				(MAR).	
	interview with L	PN #7 on 5/10/11 at 1:50				
	P.M., indicated s	he did not offer Resident			IV. The DON or her designed	
	#35 her physiciai	n ordered Med Pass			conducting quality improvem	• • • • • • • • • • • • • • • • • • •
	because Resident	t #35 didn't like the taste			audits to ensure that physicial ordered supplements are	an   nk
	and wouldn't drir	nk it. LPN #7 indicated			provided as ordered. A rand	om
	the Med Pass sur	oplement was ordered by			sample of 5 residents are be	I
	-	cause the resident had a			reviewed weekly for 30 days	
	weight loss "last				monthly for 6 months. This a	
	Weight 1000 hast				includes a visual observatior see that the resident was	ı to
	A Medication and	d Treatment Record for			administered the supplemen	t and
		icated she drank 100% of			that the supplement was	
					documented accurately. The	e
		5/10/11 at 9:00 A.M. An			interdisciplinary nutrition at ri	isk
		PN #7 on 5/10/11 at 1:50			(NAR) committee will assist i	• • • • • • • • • • • • • • • • • • •
	· ·	he had documented			monitoring during weekly NA	
		nk 100% of her Med			meetings. Results of all aud will be provided to the facility	• • • • • • • • • • • • • • • • • • •
	Pass on 5/10/11 a	at 9:00 A.M			Quality Assurance Committe	
					monthly for additional	
	A physician's ord	ler for Resident #35,			recommendations if necessa	ıry.
	dated 5/10/11 at	1:50 P.M., indicated the				
	following: Disco	ontinue Med Pass 90				
	_	neals. Call placed to the				
		er. Order received to				
	discontinue Med					

000157

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MU  A. BUILI  B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPL 05/12/2	ETED
	PROVIDER OR SUPPLIER	L ATION CONVALESCENT CENTE		STREET A	DDRESS, CITY, STATE, ZIP CODE EST U.S. 40 FIELD, IN46140	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Resident #35, da indicated the foll been refusing her reference was averecord she had be Pass supplement.  Resident #35's Mark Record indicated of her Med Pass Med Pass was or An interview wit 5/11/11 at 1:50 Pathe supplements unsure what Med S/11/11 at 5:00 Part following: Resta Document percent medication and the Anurse's note for 5/11/11 at 5:00 Part following: Resta Document percent medication and the Anurse's note for 5/11/11 at 5:00 Part following: Residual Residual Pass Practitioner. Residual Pass at this	Iedication and Treatment Is she had consumed 100% except twice, since the dered on 4/15/11.  The Resident #35 on I.M., indicated she liked provided to her but was It Pass was.  In for Resident #35, dated I.M., indicated the part Med Pass 90 ml T.I.D. Intage consumed on the reatment record.  In Resident #35, dated I.M., indicated the lent with new order to 190 ml T.I.D. per Nurse 191 middle the 191 middle the 192 ml T.I.D. per Nurse 193 ml T.I.D. per Nurse 194 ml T.I.D. per Nurse 195 ml T.I.D. per Nurse					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP - 05/12/2	LETED
	PROVIDER OR SUPPLIER	TATION CONVALESCENT CENTE	5430 W	ADDRESS, CITY, STATE, ZIP COD /EST U.S. 40 IFIELD, IN46140	)E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	of Nursing (ADC A.M., indicated at the previous ever was accepting of The ADON indic Resident #35 had Med Pass, excep 4/15/11. The AD had signed off Reseven times since those times indicated	th the Assistant Director DN) on 5/12/11 at 10:40 she trialed Resident #35 ning and Resident #35. The Vanilla Med Pass. Cated per documentation, d consumed 100% of her at twice, since ordered on DON indicated LPN #7 resident #35's Med Pass or it was ordered and 5 of the test at the State Resident #35. The other 2 times d 50%.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
		15525 <i>1</i>	B. WING		<del></del>	05/12/2	011
			D. WIIW		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER				EST U.S. 40		
SUGAR CI	REEK REHABILITA	ATION CONVALESCENT CENTER	2		FIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F9999	State Findings		F9	999			05/27/2011
					F9999 3.1-14 PERSONNEL		
	required for each within one (1) more employment. The include a tuberculous Mantoux method administered by produce the documentation of department-approximation intradermal tuberculous shall be reconstitive reaction result shall be reconstitive reaction with the and by whom addituberculin skin tender the employee stands assure the formulation one (1) month produce the standard personner at least annually monpaid personners or tuberculous workers who havenegative tuberculous.	amination shall be employee of a facility onth prior to e examination shall llin skin test, using the (5 TU PPD), persons having f training from a oved course of instruction berculin skin testing, ording unless a previously can be documented. The corded in millimeters of the date given, date read, ministered. The est must be read prior to orting work. The facility			It is the practice of Sugar Creater to ensure that facility personnel receive a physical examination within 1 month proceedings and documentation of training froodepartment approved course instruction in intradermal tuberculin skin testing reading and recording unless a previous positive reaction can be documented. The result is recorded in millimeters of induration with date given, daread, and by whom administed tuberculin skin test is reaprior to the employee starting work. At the time of employment and at least and thereafter employees and nonpaid personnel are scree for tuberculosis. For health of workers who have not had a documented negative tuberculs win test during the preceding months, the baseline tuberculs kin testing employs the two method. If the first step is negative a second test is performed 1-3 weeks after the first step.	orior ation t ing m a of g ous ate ered. ad J nent ually ned care ulin g 12 lin step	

li '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155254	B. WIN			05/12/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CLICAD	ODEEN DELIABILIT	ATION CONVALESCENT CENTE	·D	1	EST U.S. 40		
	_	ATION CONVALESCENT CENTE	:K	GREEN	IFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	MPLETION  DATE
IAU			+	IAG	DEFICIENCE 1		DAIE
		in skin testing should			I. LPN #5 and CNA #4 are no	,	
		step method. If the first			longer employed at the facilit	y.	
	1 1	a second test should be			CNA's #1, #3, and #6 had a		
		) to three (3) weeks after			xray completed during survey which found no active diseas		
	_	e frequency of repeat			They have also been given the	I .	
		nd on the risk of infection			tuberculin skin test.		
	with tuberculosis						
	TOTAL CONTRACTOR				II. New employee files have I		
	1	as not met as evidenced			audited to ensure tuberculin testing has been completed.	skin	
	by:				testing has been completed.		
					III. The facility has a policy		
		review and interview, the			regarding tuberculin skin test		
	1 *	assure the personnel files			The policy has been reviewe	d	
		employees included			and found to be complete.  Department managers have	heen	
		e results of the second			re-educated on this policy. In		
	1 -	tuberculin skin test			addition, a tickler file has bee		
	l '	<sup>4</sup> 6, and LPN #5) and			completed to allow for improv		
		ne personnel files for 2 of			tracking of administration and results of new employee	7	
		ees included verification			tuberculin skin testing.		
	of the results of t	he first and second step			3		
	in a two-step tube	erculin skin test (CNA #1			IV. The Human Resources		
	and CNA #4).				Director or her designee is		
					completing ongoing quality improvement audits of new		
	Findings include	:			employee files. This audit		
					includes the administration a	I .	
	During a review	of 7 employee files			results of the first step tubero		
	provided by the A	Administrator on 5/9/11			skin test and the second step when applicable. Results of		
	at 11:52 AM, the	verification of a second			audits will be provided to the	۵	
	step in a two-step	tuberculin skin test			facility's Quality Assurance		
	could not be four	nd in the files for CNA			Committee monthly for additi		
	#3, CNA #6, and	LPN #5. Verification			recommendations if necessa	ry.	
	could not be four	nd for step one or two in					
		rulin skin test for CNA #1					
	and CNA #4.						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMP - 05/12/2	LETED
	PROVIDER OR SUPPLIER	ATION CONVALESCENT CENTE	STREET A 5430 W	ADDRESS, CITY, STATE, ZIP CO /EST U.S. 40 IFIELD, IN46140	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	started working of 5/12/11 at 10: Administrator incremember having	with the Administrator 50 AM, the				